# Report on Proposal for a Prescription Drug Assistance Program for Low-Income Elderly and Disabled

**Submitted to the North Carolina General Assembly**

**By the North Carolina Department of Health and Human Services**

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# Summary of Recommendations

The North Carolina Department of Health and Human Services was directed by the North Carolina General Assembly to develop a proposal for the establishment of a prescription drug assistance program for low-income elderly and disabled persons. The Department designated the Division of Aging to take the lead in the development of the proposal. The Division of Aging convened a broad based group of 35 persons representative of consumers and advocates from the aging and disability communities, providers of services, pharmaceutical companies, private foundations, and other relevant groups including state agencies with an interest in this matter to serve on a work group to have input into the development of the proposal. The work group met over the course of four months and the first priority recommendation from the work group is as follows:

The work group recommends that the North Carolina General Assembly consider giving priority to establishing a prescription drug assistance program with the following components:

- Persons eligible for the program should be those who are 65 and over or disabled who are not eligible for full Medicaid benefits and are enrolled in Medicaid as Qualified Medicare Beneficiaries (QMB's) or Specified Low-Income Medicare Beneficiaries (SLIMBY's). These individuals have income no greater than 120% of the federal poverty level and countable assets of $4000 or less for an individual and $6000 or less for a couple. As of February 2000, there were 21,386 aged and disabled persons identified as QMB's and SLIMBY's in the state.
- All medical conditions should be covered under the program.
- Coverage should be capped at the average annual per person Medicaid cost for prescription drugs for aged and disabled persons. For SFY 2001, the average annual Medicaid cost per person is projected to be $2,476 for those 65 and older and $2,422 for disabled adults.
- Program participants should pay a co-pay for each prescription equal to the amount of the Medicaid dispensing fee plus the claims processing fee. This is currently $6.00 per prescription.
- Manufacturers should be required to provide a rebate, not to exceed the federally established minimum rebate percentage for participation in the state Medicaid program, in order to participate in the program.
- No formulary should be utilized, however, a DUR (drug utilization review) process is recommended.
- Benefits should be coordinated with other state and federal prescription assistance programs and, to the extent possible, this program should be the payor of last resort.

The work group recommends, as its second priority, that when sufficient funds are available, the General Assembly consider expanding the program as proposed above to cover aged and disabled persons up to 150% of the federal poverty level. In the event

funds are not available to provide prescription drug coverage for those up to 150%, the work group recommends that persons between 120% and 150% of poverty be provided with prescription assistance up to $750 per year.

An additional work group recommendation is that the General Assembly consider appropriating $1 million in recurring funds to support the efforts of local prescription drug assistance programs serving older and disabled adults to provide education and counseling services and to enhance their efforts to maximize private sector resources. If approved, it is recommended that this funding be awarded on a competitive grant basis, that a limited amount of this funding be utilized to support efforts to enhance the statewide system of prescription drug assistance programs and that efforts be devoted to seeking private resources to augment the state funding available to support this initiative.

# Prescription Drug Assistance Proposal

## Legislative Directive

In the 1999 legislative session, the North Carolina General Assembly appropriated funding for the first time to the Department of Health and Human Services to help pay for the cost of outpatient prescription drugs for persons:

1. 65 years of age and over who are not eligible for full Medicaid benefits;
2. Whose income is not more than 150% of the federal poverty level; and
3. Who have been diagnosed with cardiovascular disease or diabetes.

A total of $500,000 was appropriated and funds were directed to help pay for the cost of outpatient drugs for the treatment of cardiovascular disease or diabetes. (See Appendix 1 for a description of this program).

> *(**Note**: Due to the need to support persons impacted by Hurricane Floyd, this funding is being earmarked in State Fiscal Year 1999-2000 for prescription drug assistance in the 30 eastern North Carolina counties most severely impacted by the Hurricane and subsequent flooding).*

The General Assembly also directed the Department of Health and Human Services to work with the Fiscal Research Division of the Legislative Services Office to develop a proposal for the establishment of a prescription drug assistance program. The program is to serve low-income elderly and disabled persons who are not eligible for full Medicaid benefits and who need prescription drugs to treat a condition which, if left untreated, could result in the person's admission to a nursing facility or otherwise qualifying for Medicaid.

## Work Group Charge

The Department of Health and Human Services designated the Division of Aging to take the lead in developing a proposal for a prescription drug assistance program. The Division of Aging convened a broad based group of 35 persons representative of consumers and advocates from the aging and disability communities, providers of services, pharmaceutical companies, private foundations, and other relevant groups including state agencies with an interest in this matter to have input into the development of the proposal. (See Appendix 2 for a list of work group members). The work group met during the course of four months and developed the recommendations for the proposal presented in this report. The 1997 report completed by the Division of Aging entitled "A Study of Options for Making Prescription Drugs More Affordable for Older Adults" was used as a starting point for work group deliberations.

During the course of deliberations, the work group addressed the following issues:

- The extent of the prescription drug affordability problem for older and disabled adults.
- Efforts being considered at the federal level to address prescription drug affordability.
- Prescription drug assistance programs offered in other states and those available in North Carolina.

- Local prescription drug assistance programs in North Carolina.

- Prescription drug utilization under the Medicaid program in North Carolina.
- Private sector responses to prescription drug assistance.
- Factors/variables to consider in the development of a state funded prescription drug assistance program.
- Cost projections for different assistance program scenarios.
- Administration and implementation of a prescription drug assistance program.

## Prescription Drug Affordability

Paying for prescription drugs is a problem for many older and disabled adults in North Carolina as evidenced by the fact that this issue consistently ranks at the top of unmet needs identified by these groups. A review of requests for help received by CARELINE in the Department of Health and Human Services and by the agencies within the Department further validates the fact that this is one of the most critical needs facing older and disabled North Carolinians. Study results vary as to the out-of-pocket costs paid for prescription drugs by the elderly and disabled. Data does support, however, that people over the age of 65 pay more now for their drugs than they do for doctor's care and that spending for prescription drugs is growing annually at double digit rates – faster than other components of health care spending.[1]

The Health Care Financing Administration (HCFA) estimates that in 2000, older and disabled fee-for-service Medicare beneficiaries will spend an average of $1,370 per person for prescription drugs.[2] Data published in the March/April 2000 edition of the journal Health Affairs notes that spending on drugs for an elderly person averaged $1,100 a year in 1998 with 5% of older persons using more than $4,100 in drugs and 1% using more than $6,600.[3] Data provided by the North Carolina Division of Medical Assistance shows that for State Fiscal Year 1999, Medicaid expenditures for prescription drugs totaled approximately $198,000,000 for persons 65 and over, $2,700,000 for persons who are blind, and $258,000,000 for persons who are disabled.[4] For SFY 2001, the projected annual average Medicaid costs for prescription drugs per person is projected to be $2,476 for those 65 and older and $2,422 for disabled adults. Although there is data to suggest that persons who have Medicaid or other health insurance coverage which includes a prescription benefit have a higher drug utilization rate than those without prescription drug coverage, these figures do give an indication of prescription drug use by older and disabled adults in our state.

Many older adults and those who are permanently and totally disabled look to Medicare as their main source of health insurance coverage. Medicare, however, generally does not cover the cost of out-patient prescription drugs. Some older and disabled adults eligible for Medicare purchase a Medicare Supplement (Medigap) policy to cover gaps in Medicare coverage. Only three of the ten nationally standardized Medigap plans include a prescription drug benefit and the cost of these plans is out of reach of many low and moderate income persons. Medigap policies sold in North Carolina with a drug benefit currently range in price from $138 to $366 for monthly premiums.[5] At this time, none of the Medigap policies with a prescription drug benefit are available to disabled Medicare beneficiaries in the state. Nationally, only14% of Medigap policyholders purchased a plan with a drug benefit.[6]

Some older and disabled adults also have employer sponsored health care coverage which includes a prescription drug benefit. Persons with such a benefit are more likely to have a higher income and to be younger and better educated than their counterparts without drug coverage.

On April 10 of this year, a report was released by the U.S. Department of Health and Human Services (HHS)[7] on prescription drug coverage, spending, utilization, and prices. The report further supports the point made in this document that affording prescription drugs is a big problem for many older and disabled adults. Key findings from the HHS report include the following:

- People with insurance coverage for prescription drugs not only fill more prescriptions than those without coverage, they are likely to have access to a broader array of therapies, including more costly therapies. People without drug coverage face greater financial burdens and may sometimes be unable to follow the courses of treatment ordered by their physicians.
- Seniors without prescription drug coverage not only lack insurance against high costs, but they do not have access to the discounts and rebates that insured people receive.
- Older Americans and people with disabilities without drug coverage typically pay 15% more than insurers who negotiate price discounts for the same prescription drug.
- Among beneficiaries with five or more chronic conditions, those with drug coverage have much higher total spending ($1402 versus $944) and much lower out-of-pocket spending ($412 versus $944) than beneficiaries without coverage.
- The gap between drug prices for people with and without insurance discounts nearly doubled, from 8% to 15%, between 1996 and 1999. These differences do not take into account manufacturers' rebates which could widen the gap by an additional 2% to 35%.
- Prescription drug spending and utilization is growing rapidly – more than twice the growth in other health care spending. Between 1993 and 1998, spending nationwide for prescription drugs increased at an annual rate of 12% compared to about 5% for all other types of health spending. Prescription drugs now account for about one-sixth of all out-of-pocket health spending for the elderly.
- The percent of Medicare beneficiaries without drug coverage who report not being able to afford a needed drug is about five times higher than those with coverage.
- Uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out-of-pocket.
- Nearly half of Medicare beneficiaries do not have coverage for prescription drugs for the entire year. Drug coverage is likely to decline as fewer employers offer health benefits to future retirees. One employer survey recorded a drop from 40% in 1993 to 28% in 1999 in the number of large firms offering health benefits to Medicare eligible retirees.
- Rural and older beneficiaries are particularly vulnerable. Rural Medicare beneficiaries are over 50 % more likely to lack prescription drug coverage for the entire year than urban beneficiaries (43% to 27%). People age 85 and older are one-third more likely to lack coverage than those ages 65 to 69 (37% to 28%).

## Prescription Drug Assistance – What is Available

**Developments at the National Level**

As noted above, Medicare does not generally cover out-patient prescription drugs and, there is no other universal prescription drug assistance program for older or disabled adults at the national level. Because of the increased attention to the prescription drug issue, there are currently almost three dozen bills related to Medicare and prescription drug coverage before the U.S. House of Representatives or the Senate. President Clinton has also proposed a new and voluntary outpatient Medicare prescription drug benefit for all Medicare beneficiaries which would have no deductibles and would pay half of participants' drug costs up to a limit of $5,000 when fully implemented. The proposal also includes a stop-loss provision to protect beneficiaries against catastrophic drug costs.[8] Extensive debate is expected on the issue of prescription drug assistance as it has been dubbed by numerous political analysts as the "hottest issue in Washington" this election year.

In another development on the national level, the National Association of Insurance Commissioners decided at their March 2000 meeting to study whether to require all 10 of the nationally standardized Medigap plans to include a prescription drug plan. The Association is to make recommendations to Congress by the end of the year on this issue.[9]

**Initiatives Undertaken by Other States**[10]

In recognition of the difficulty many older and disabled adults have in paying for prescription drugs, numerous states have developed state administered prescription drug assistance for the elderly and seven of these states offer at least some benefit to certain disabled persons. Annual income requirements for these programs range from 100% of the federal poverty rate ($8,350 for 2000) to $18,500 for individuals, and from $10,050 to $24,400 for couples. Cost sharing among the state programs varies, ranging from a $15 per month deductible to co-payments of $.25 per prescription to 50% of the cost per prescription. Most states have an open formulary (cover most prescription drugs), however, several states cover only maintenance drugs such as those for high blood pressure and diabetes. States vary in how they finance their prescription drug assistance programs. Revenue sources include state lottery funds, private foundation funding, cigarette taxes, sales taxes on construction materials, general revenue funds, and state tobacco settlement funds. Two states have an asset limit as well as an income limit (Michigan - $3,000 and Minnesota - $6,000).

Two states offer drug program discounts: California, which passed legislation in 1999 which requires pharmacies that participate in the Medicaid program to make prescription drugs available to Medicare beneficiaries at the Medicaid rate, and Maine, which offers discounts based on the Medicaid average rebate to all state residents without third party drug coverage.

The state of Massachusetts has started a program called "Pharmacy Program Plus", which provides unlimited prescription benefits to the elderly and disabled who spent at least 10% of their gross monthly household income (up to 500% of poverty) on prescription drugs in three of the last six months.

Two states have gone the tax credit route in order to assist their residents with prescription drugs. Existing laws in Michigan allow residents age 65 and older, with household incomes under 150% of the federal poverty level, to obtain a refundable tax credit up to $600 for prescription drug purchases. Missouri enacted legislation which took effect January 1, 2000, that created a pharmaceutical tax credit up to $750 per year for persons with incomes under $13,500.

In an attempt to further address the issue of providing relief to persons in need of prescription drug assistance, several states are also pursuing such options as rebate programs with drug manufacturers and bulk purchasing arrangements.

**State Efforts**

For persons who are Medicaid eligible, generally, Medicaid will cover up to six prescriptions per month with a $1.00 co-payment for each prescription. In addition to the $500,000 appropriated in the last legislative session for prescription drugs to treat cardiovascular disease and diabetes for low-income elderly, the Division of Aging is aware of seven programs that receive small state appropriations to help with prescription drug costs. Generally, eligibility for this funding is restricted to non-Medicaid eligible low-income persons with specific medical problems (e.g. epilepsy, HIV-AIDS, mental illness, end-state renal disease/kidney transplant recipients) or as part of an overall treatment plan for persons in specialty care programs such as migrant health care or for vocational rehabilitation programs.

**Local Initiatives**

In response to the need for assistance with prescription drugs, approximately 30 communities in North Carolina have established local Prescription Drug Assistance Programs. These vary in scope and sophistication from programs that operate full time with several paid staff and are affiliated with programs such as free clinics or county medical societies to those that are open once or twice per month and are staffed by community volunteers. These programs typically rely on accessing drug manufacturer indigent care programs to get free drugs for specific individuals, on using sample drugs from drug manufacturers, or on providing financial support to enable eligible persons to purchase their own prescriptions from retail pharmacies. In addition to helping individuals obtain prescription drugs, providing consumer information and drug education counseling is a major component of some of these programs. They have proven very successful in their efforts to help older and disabled adults obtain needed medications and to use these properly.

## Work Group Deliberations

In deciding on recommendations to include in the proposal for a prescription drug assistance program, the work group looked at a number of factors/variables. Included among these were the following:

- How do you define the elderly and the disabled population to be included?
- How do you define low-income?
- Should assets be considered in addition to income for eligibility purposes?
- What medical conditions should be covered?
- Should all drugs be covered or should a formulary be proposed?

- Should there be limits (caps) on coverage or cost sharing by beneficiaries?
- What are the projected costs of the different scenarios of coverage?

After careful deliberations, the work group made the decision that the proposal should be aimed at providing prescription drug assistance to those older and disabled adults who are the most vulnerable due to their inability to pay for prescription drugs because of their low-income. It was agreed that elderly should be defined as those persons who are 65 and over and the definition for disabled should be consistent with the definition utilized by Medicare for the disabled (be on Social Security or Railroad Retirement disability benefits for more than 24 months).

In making decisions relative to the additional aspects of the proposal, the work group reviewed a broad array of coverage scenarios and associated cost estimates prepared by staff of the Division of Facility Services. To make it easier for the work group to evaluate various program coverage proposals, cost scenarios were divided into three major categories.

The first category targets those identified as being the most vulnerable with regard to the ability to obtain needed prescription drugs. Consistent with the recommendations included in the October 1997 report "A Study of Options for Making Prescription Drugs More Affordable for Older Adults", this category includes elderly and disabled adults not eligible for full Medicaid and enrolled in Medicaid as Qualified Medicare Beneficiaries (QMB's) and Specified Low-Income Medicare Beneficiaries (SLIMBY's). Coverage by Medicaid for certain Medicare related costs is an entitlement for these individuals. It is important to note that the number of QMB's without full Medicaid coverage has decreased significantly since January 1, 1999 as a result of action taken by the General Assembly to increase the categorically needy income eligibility level to 100% of the federal poverty level for the aged, blind, and disabled. To illustrate this point, the October 1997 report mentioned above projected a total of 57,955 aged and disabled QMB's/SLIMBY's without full Medicaid coverage for State Fiscal Year 1998-99. The actual number of enrolled QMB's/SLIMBY's without full Medicaid coverage as of February 2000 was 21,386.[11]

**Who are QMB's and SLIMBY's?**

| | |
|---|---|
| QMB's | have income up to 100% of poverty and countable assets of $4,000 or less ($6,000 or less for a couple). Medicaid pays the Medicare Part B premium which covers doctor visits, surgery, therapy, home health care, etc. (currently $45.50 per month) as well as all applicable Medicare co-pays and deductibles. *(Medicaid also pays the Part A premium for persons for whom a Part A premium charge applies -- which is not the norm.)* |
| SLIMBY's | have income between 101% and 120% of poverty. This group must meet the same asset limits indicated above for QMB's. For this group Medicaid covers only the monthly Medicare Part B premium. |

***Note**: 100% of poverty equates to $8,350 annually ($11,250) for a couple and 120% equates to $10,020 annually ($13,500 for a couple).*

The second category includes a broader group of individuals receiving help from Medicaid for certain Medicare related costs. In addition to QMB's and SLIMBY's, this group includes elderly and disabled adults enrolled in Medicaid to receive help with the monthly premium for Medicare Part B. Countable assets are the same as for QMB's and SLIMBY's. Enrolled individuals with income between 121-135% of poverty also have their entire Medicare Part B premium covered. Enrolled persons with income between 136% and 175% of poverty, however, currently receive $2.87 per month toward their Medicare Part B premiums which is paid annually based on the number of eligible months for the year for a maximum of $34.44 per year. Participation in these two assistance categories is not an entitlement. Federal funds are capped and, as such, enrollment is contingent upon the availability of federal funds.

*Note: 135% of poverty equates to $11,272.50 annually ($15,187 for a couple) and 175% of poverty equates to $14,612 annually ($19,687 for a couple).*

The third category of cost estimates targets elderly and disabled persons up to 150% of poverty. Cost estimates for this category also assume that persons would have to meet the same asset test as used for QMB's and SLIMBY's.

Cost estimates developed for each category included estimates to cover persons in need of prescription drugs for certain conditions as well as estimates to cover prescription drugs for the targeted population regardless of condition. Disease specific estimates are limited to diabetes and cardiovascular disease. Cost estimates to treat additional medical conditions were not developed due to the fact that adding other medical conditions to the mix could result in percentages of eligible persons reaching in excess of 100% (of persons who otherwise met the income and asset criteria) since there is no known way to unduplicate the number of persons who have various combinations of medical conditions. For instance, based on national data, the overall prevalence rate for cardiovascular disease among the elderly is 70.1%.[12] The overall prevalence rate for diabetes among North Carolina older adults is 15.2%. [13] The combined (duplicated) prevalence rates for these two diseases alone is 85.3%. Thus, the more conditions included, the more the eligible population is skewed. For this reason, combined with the fact that estimates were developed to cover the entire projected eligible population regardless of condition, the work group limited disease specific cost estimates to the two medical conditions currently being targeted by the pilot project (diabetes and cardiovascular disease). Prevalence rate data for the elderly for several other medical conditions are listed below for informational purposes only:

Selected Respiratory Diseases -- 13.8% [14]
Arthritis-- 48.9% [15]
Cancer -- incidence rate of 1.89% (17,819 people 65 and over diagnosed with cancer in 1997)[16]

## Key Program Design Features Recommended by the Work Group

- All medical conditions be covered
- A co-pay be charged for each prescription filled and the amount of the co-pay be tied to the Medicaid dispensing fee (currently $5.60) plus the cost to cover claims processing (currently 40 cents) for a co-pay of $6 per prescription.

  *Note: A $15 co-pay was also considered and is reflected in some cost estimates not ultimately recommended by the work group. The $15 co-payment is based on an average of the co-pay*

*structure used for prescription drug coverage through the State Health Plan which uses a tiered approach depending upon whether brand or generic drugs are used.*

- 100 day supply per prescription be allowed if appropriate (with a single co-pay amount).
- No formulary be used, however, a drug utilization review (DUR) process is recommended to provide feedback to prescribers and providers on elements of drug usage. The decision was made to not recommend a formulary so as to stimulate competition among drug manufacturers to participate in the program, to increase the probability of securing rebates from drug manufacturers, and to also allow doctors flexibility in prescribing medications for their patients.
- Manufacturers be required to provide a rebate not to exceed the federally established minimum rebate percentage for participation in state Medicaid programs (currently 15.1% for brand name drugs and 11% for generic). Manufacturers could voluntarily exceed the minimum rebate required.
- Assistance should be coordinated with other state and federal prescription assistance programs and, to the extent possible, this program should be the payor of last resort.

## Cost Estimates for Work Group Recommended Assistance Program Scenarios

The work group priority ranked three coverage scenarios. Their top priority is targeted to the most vulnerable population (aged and disabled QMB's and SLIMBY's). The two other scenarios target a broader population that includes aged and disabled adults up to 150% of poverty. All three estimates assume that participants would not have other coverage for prescription drugs and that all participants would meet the same asset levels as established for QMB's and SLIMBY's. Please note that for cost estimates #2 and #3, a range of projected annual costs and persons to be served is provided. A range is provided for these scenarios since no data is available regarding asset levels based on income. Therefore, assumptions had to be made regarding the percentage of persons meeting the income limit who would also meet the established asset limit. The low end of the range for work group priorities #2 and #3 assumes that 30% (probably a more realistic estimate) of income eligible persons would also meet the asset limit. The high end of the range assumes that 50% (assumed to be a worse case scenario) of income eligible persons would meet the asset limit. Making an assumption about the percentage of income eligible individuals that would meet the asset level is not an issue for priority #1 since all of these individuals have been determined to meet the established asset level by virtue of their QMB/SLIMBY status.

Although the work group recommends manufacturer's rebates consistent with the minimum rebate required for participation in Medicaid, the work group deliberated whether to include the impact of the rebates on cost estimates of the various program coverage scenarios. The work group discussed whether manufacturers would be willing to participate in this program if the same minimum rebate level required for Medicaid were also required for this program. Also, after examining one set of cost estimates that included rebates and another set of cost estimates that excluded rebates, the work group decided that cost estimates should not include rebates in order to provide a "worse case" cost scenario. In addition, excluding rebates from the cost estimates would make it easier to adjust the cost estimates to reflect rebate levels other than the level recommended by the work group.

A comprehensive listing of cost estimates and coverage scenarios considered by the work group is included as Appendix #3. In the interest of being complete, a comprehensive listing of cost estimates and coverage scenarios that calculates the impact of a manufacturer's rebate is included as Appendix #4. A complete listing of assumptions upon which the cost estimates are based is included as Appendix #5. A list of the three coverage scenarios recommended by the work group is found on the next page.

## Priority #1 -- Cost Estimate Targeting the Most Vulnerable

(1) Provide the same average per person annual benefit as Medicaid for aged and disabled QMB's/SLIMBY's regardless of condition with a $6 co-pay.*

| State Fiscal Year | Cost Estimate | Persons Served |
|---|---|---|
| SFY 2001 | $ 51.3 million | 21,253 |
| SFY 2002 | $ 61.0 million | 22,432 |
| SFY 2003 | $ 72.5 million | 23,629 |
| SFY 2004 | $ 85.9 million | 24,861 |
| SFY 2005 | $101.8 million | 26,150 |

## Priority #'s 2 & 3 -- Cost Estimates Targeting a Broader Low-Income Population (Aged/Disabled Adults Up to 150% of Poverty)

(2) Provide the same average per person annual benefit as Medicaid regardless of condition with a $6 co-pay.

| State Fiscal Year | Cost Estimate | Persons Served |
|---|---|---|
| SFY 2001 | $198.2 million to $330.4 million | 81,786 to 136,310** |
| SFY 2002 | $223.5 million to $372.5 million | 81,770 to 136,284** |
| SFY 2003 | $252.6 million to $421.0 million | 82,003 to 136,671** |
| SFY 2004 | $286.1 million to $476.8 million | 82,407 to 137,345** |
| SFY 2005 | $325.4 million to $542.4 million | 83,192 to 138,653** |

(3) Provide same average per person annual benefit as Medicaid for QMB's/ SLIMBY's and $750 maximum annual benefit for other aged/disabled adults up to 150% of poverty regardless of condition with $6 co-pay.

| State Fiscal Year | Cost Estimate | Persons Served |
|---|---|---|
| SFY 2001 | $ 96.7 million to $137.6 million | 81,786 to 136,310** |
| SFY 2002 | $105.5 million to $146.4 million | 81,770 to 136,284** |
| SFY 2003 | $116.3 million to $157.3 million | 82,003 to 136,671** |
| SFY 2004 | $129.1 million to $170.3 million | 82,407 to 137,345** |
| SFY 2005 | $144.6 million to $186.2 million | 83,192 to 138,653** |

***Note: The same average per person cost for Medicaid assumes an annual base rate of $2,476 in 2001*

*for elderly QMB's/SLIMBY's and $2,422 for disabled QMB's/SLIMBY's. Cost estimates for out years are adjusted for inflation at a rate of 12.5% annually (annual cost data and total projection of QMB's/SLIMBY's by year, provided by the Division of Medical Assistance (4/5/2000). Ratio of elderly to disabled QMB's/SLIMBY's based on actual ratio* of QMB's/SLIMBY's as of 2/10/2000.

***Note: Reflects the range in costs and persons projected to be served based on assumption that at least 30% of income eligibles will also meet the QMB/SLIMBY asset limit and a maximum of 50% of income eligibles will also meet the asset limit.*

## A Sample of Other Cost Estimates and Coverage Options Considered by Work Group

As mentioned previously, the work group considered a wide variety of options. Some examples of other options considered by the work group are listed below. All costs estimates are for 2001.

- Provide aged/disabled QMB's/SLIMBY's with $500 maximum annual benefit regardless of condition with a $6 co-pay

| **Cost Estimate SFY 2001** | **Persons Served SFY 2001** |
|---|---|
| $10.6 million | 21,253 |

- Provide the same average annual per person cost as Medicaid for aged/disabled QMB's/SLIMBY's with diabetes and/or cardiovascular disease only with a $6 co-pay.

| **Cost Estimate SFY 2001** | **Persons Served SFY 2001** |
|---|---|
| $16.3 million | 14,106 (duplicated) |

- Provide a maximum $300 annual benefit for aged/disabled adults up to 150% of poverty regardless of condition with co-pay of $6 or $15.

| **Asset Test** | **Cost EstimateSFY 2001** | **Persons Served SFY 2001** |
|---|---|---|
| Assume 30% meet asset test | $24.5 million | 81,786 |

| | | |
|---|---|---|
| Assume 50% meet asset test | $40.9 million | 136,310 |

## Recommendation to Support Local Prescription Drug Assistance Programs

In the course of examining resources to assist low-income older and disabled adults to obtain prescriptions drug, the work group was impressed with the work that is being done by the local prescription drug assistance programs across the state. Not only are these programs effective in their diligent efforts and creative approaches to helping people receive the prescription drugs they need, many of these programs are also providing consumer information and drug education counseling to the people they serve which helps to ensure the proper utilization of their drugs. The feeling of the work group members was that local programs could maximize their efforts if additional resources were available to them. For this reason, the work group is also recommending that when sufficient funds are available the General Assembly consider providing $1 million in recurring funds to support the efforts of local assistance programs. It is the work group's further recommendation that this funding be awarded on a competitive grant basis, and that a limited amount of the funding be utilized to support efforts to enhance the overall system of prescription drug assistance programs. Efforts should be devoted to seeking private resources to augment the state funding available to support this effort.

## Administration and Implementation of Proposal Plan

It is the recommendation of the work group that the Department of Health and Human Services be given the responsibility for implementing the proposed statewide prescription drug assistance program and competitive grant program targeted to local programs. Any funds appropriated to support a statewide assistance program should be coordinated with the funding which was appropriated in 1999 to help pay for the cost of outpatient drugs for the elderly to treat cardiovascular disease and diabetes. Although there is debate at the federal level relative to prescription drug assistance, the work group members feel that the state should move ahead in efforts to develop a state funded assistance program. Should action be taken by Congress to establish a prescription drug benefit for Medicare beneficiaries, state funding should be used to augment these efforts to ensure that those who are the most vulnerable with regard to their ability to obtain needed prescription drugs are helped.

It is a further recommendation of the work group that funds should also be appropriated to the Department of Health and Human Services for the administration and management of the prescription drug assistance program as proposed. Sufficient funds will be generated from the $6.00 per prescription co-pay to cover only the dispensing fees and the claims processing fees associated with the program. It is projected that four full-time staff (program manager/ administrator, pharmacist, data analyst, and administrative assistant) and a budget of $275,000 will be needed to manage a prescription drug assistance program for QMB's/SLIMBY's regardless of condition (first priority recommendation of work group). Should the program be funded at a level different from that proposed, staffing needs would have to be re-evaluated. Program staff, in addition to managing the program, should also be charged with taking the lead in exploring avenues for developing public/private partnerships to support prescription assistance efforts.

**Appendix 1**

# Description of Prescription Assistance Program Approved in 1999 Legislative Session

EFFECT OF LEGISLATION
House Bill 168, Part XI, Subpart 1, Section 11.1(a), 1999 Session

BENEFIT: Program will pay for outpatient prescription drugs for the treatment of cardiovascular disease or diabetes at a rate not to exceed the Medicaid cost, including rebates.

BENEFICIARIES: Persons over the age of 65 and not eligible for full Medicaid benefits, whose income is not more than 150% of the federal poverty level, and who have been diagnosed with cardiovascular disease or diabetes.

FUNDING: $ 500,000 per year for FY 1999-2000 and FY 2000-2001.

MANDATE: The Department of Health and Human Services shall develop criteria to maximize the efficient and effective distribution of these drugs.

SERVICE AREA for SFY 1999-2000: Counties most severely impacted by Hurricane Floyd (Beaufort, Bertie, Bladen, Brunswick, Carteret, Columbus, Craven, Duplin, Edgecombe, Greene, Halifax, Hertford, Hyde, Johnston, Jones, Lenoir, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Pitt, Robeson, Sampson, Washington, Wayne, and Wilson). Service Area for SFY 2000-2001 will be all counties in North Carolina.

CLIENT ELIGIBILITY and ENROLLMENT: Two-phase approach. Phase I ( first 30 days): Persons who are enrolled as Qualified Medicare Beneficiaries (QMB's) or Specified Low-Income Medicare Beneficiaries (SLIMBY's). Phase II: Others up to 150% of federal poverty level.

CLIENT IDENTIFICATION: Phase I - Division of Medical Assistance (DMA); Phase II DMA and Division of Social Services (DSS).

CLAIMS PROCESSING/MANAGEMENT REPORTS: Pharmacy Network National Corporation. Services to include issuance of identification cards, provider notification, claims processing and provider reimbursement, utilization and fiscal reports, and rebate management.

FORMULARY: Prescription drugs used for the treatment of hypertension, angina, arrhythmia, heart failure, and diabetes mellitus.

DEDUCTIBLE/CO-PAY PROVISIONS: $0 deductible; $6.00 co-pay per prescription.

PROVIDER ENROLLMENT: Any willing provider.

PROVIDER REIMBURSEMENT: Same rate as Medicaid (Average Wholesale Price minus 10%). Claim processing fee not to exceed $.40 to be deducted from reimbursement as offset to $6.00 co-pay.

IMPLEMENTATION RESPONSIBILITY: Division of Public Health.

PROGRAM ADVISORY GROUP: Public Health, Aging, Medical Assistance, DHHS, Industry, Academia, Advocacy Groups, Pharmacy Association, Medical Community.

ADMINISTRATIVE SUPPORT COST: $50,000.

RULEMAKING: Propose/implement temporary rules and establish final rules per Secretary's rule-making authority.

**Appendix 2**

## Prescription Drug Assistance Proposal Work Group Members

Karen Adams-Gildchrist, Easter Seals of North Carolina
Bob Allen, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Deborah Baldwin, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Andrew Barrett, Pharmacy Network National Corporation
Phillip Belcher, Duke Endowment
Barbara Brooks, N.C. Division of Medical Assistance
Bonnie Cramer, N.C. Division of Facility Services
Doris Dick, N.C. Senior Tar Heel Legislature
Mildred Farrington, Center for Minority Aging, UNC Institute on Aging
Mary Flynn, N.C. Senior Tar Heel Legislature
Dan Garrett, N.C. Association of Pharmacists
Karen Gottovi (Chair of Work Group), N.C. Division of Aging
Susan Harmuth, N.C. Division of Facility Services
Chris Hoke, N.C. Department of Health and Human Services - Office of Intergovernmental Affairs
Donna Holt, N.C. Division of Vocational Rehabilitation Services
Dr. Joe Holliday, N.C. Division of Public Health (replaced by Dr. Betty Wiser when he changed jobs)
Bob Jackson, AARP
Ann Johnson, Governor's Advisory Council on Aging
Gail Kelley, N.C. Office of Research, Demonstration, and Rural Health Development
Dr. Stephen Kearney, UNC-CH School of Pharmacy and Pfizer U.S. Pharmaceuticals
Wanda Mandeville, Department of Health and Human Services - Division of Budget, Planning and Analysis
Barbara Matula, N.C. Medical Society Foundation
David Moser, N.C. Association of Area Agencies on Aging
Carla Obiol, N.C. Department of Insurance
Charles Reed, N.C. Division of Public Health
Benny Rideout, N.C. Division of Medical Assistance
Elizabeth Seifert, Glaxo Wellcome (replaced by Ann Waldo when she left for maternity leave)
Sara Smith, Kate B. Reynolds Charitable Trust
Carol Shaw, Fiscal Research Division of Legislative Services Office
Carolyn Smith, N.C. Independent Living Council
Hugh Tilson, N.C. Hospital Association
Gina Upchurch, Senior PHARMAssist Program
Cassie Wasko, N.C. Association on Aging
Julie White, Lt. Governor's Office
Polly Williams, N.C. Equity/N.C. Coalition on Aging

Staff to the Work Group: Mary Bethel and Bill Lamb (Division of Aging)

**Appendix 3**

# Comprehensive Listing of Cost Estimates and Coverage Scenarios Considered by Work Group for SFY 2001

**QMB/SLIMBYS -- Aged & Disabled Up to 120% of Poverty**

| | Cost | People |
|---|---|---|
| Flat Dollar Cap Approach | | |
| • Provide maximum $300 annual benefit per eligible regardless of condition (assumes either $6 or $15 co-pay) | $6.4 million | 21,253 |
| • Provide maximum $400 annual benefit per eligible regardless of condition (assumes $6 or $15 co-pay) | $8.5 million | 21,253 |
| • Provide maximum $500 annual benefit per eligible regardless of condition (assumes $6 or $15 co-pay) | $10.6 million | 21,253 |
| • Provide maximum $750 annual benefit regardless of condition (assumes $6 or $15 co-pay) | $15.9 million | 21,253 |
| • Provide maximum $300 annual benefit for all eligible with diabetes and CVD only (assumes either $6 or $15 co-pay) | $4.2 million | 14,106 (duplicated) |
| Capped Amounts Tied to Average Annual Medicaid Costs | | |
| • Provide same average annual per person cost as Medicaid regardless of diagnosis (average annual costs adjusted for inflation) with $6 co-pay per prescription | $51.3 million | 21,253 |
| • Provide same average annual per person cost as Medicaid (adjusted for inflation) regardless of diagnosis with $15 co-pay | $49.7 million | 21,253 |
| • Provide same average annual Medicaid level of assistance (adjusted for inflation) for diabetes and CVD only with $6 co-pay | $16.3 million | 14,106 (duplicated) |
| • Provide same average annual Medicaid level of assistance for diabetes and CVD only with $15 co-pay | $14.4 million | 14,106 (duplicated) |

**QMB's/SLIMBY's & QI's Up to 175% of Poverty**

| | | |
|---|---|---|
| • Provide maximum $300 annual benefit per eligible regardless of condition (assumes either a $6 or $15 co-pay per prescription) | $8.1 million | 27,000 |
| • Provide maximum $400 annual benefit per eligible regardless of condition (assumes either a $6 or $15 co-pay per prescription) | $10.8 million | 27,000 |
| • Provide maximum $500 annual benefit per eligible regardless of condition (assumes either a $6 or $15 co-pay per prescription) | $13.5 million | 27,000 |
| • Provide maximum $750 annual benefit per eligible regardless of condition (assumes either a $6 or $15 co-pay per prescription) | $20.2 million | 27,000 |
| • Provide same average annual per person cost as Medicaid regardless of condition with a $6 co-pay. | $65.1 million | 27,000 |
| • Provide same average annual per person cost as Medicaid regardless of condition with a $15 co-pay. | $63.2 million | 27,000 |

| | | |
|---|---|---|
| **Aged & Disabled Up to 150% of Poverty**<br>**Estimates below assume 50% of income eligibles also meet QMB asset test** | | |
| • Provide average annual Medicaid cost for all eligibles regardless of condition with $6 co-pay | $330.4 million | 136,310 |
| • Provide average annual Medicaid cost for all eligibles regardless of condition with $15 co-pay | $320.6 million | 136,310 |
| • Provide $300 maximum annual benefit for all eligibles regardless of condition with $6 or $15 co-pay | $40.9 million | 136,310 |
| • Provide $400 maximum annual benefit for all eligibles regardless of condition with $6 or $15 co-pay | $54.5 million | 136,310 |
| • Provide $500 maximum annual benefit for all eligibles regardless of condition with $6 or $15 co-pay | $68.1 million | 136,310 |
| • Provide $750 maximum annual benefit for all eligibles regardless of condition with $6 or $15 co-pay | $102.2 million | 136,310 |
| • Provide Medicaid average annual cost for diabetes and CVD only with $6 co-pay | $123.5 million | 105,422 (duplicated) |
| • Provide Medicaid average annual cost for diabetes and CVD only with $15 co-pay | $108.9 million | 105,422 (duplicated) |
| • Provide maximum $300 annual benefit for those with diabetes and CVD only with a $6 or $15 co-pay | $31.6 million | 105,422 (duplicated) |
| • Provide maximum $400 annual benefit for those with diabetes and CVD only with a $6 or $15 co-pay | $42.2 million | 105,422 (duplicated) |
| • Provide maximum $500 annual benefit for those with diabetes and CVD only with a $6 or $15 co-pay | $52.7 million | 105,422 (duplicated) |
| • Provide maximum $750 annual benefit for those with diabetes and CVD only with a $6 or $15 co-pay | $79.0 million | 105,422 (duplicated) |
| • Provide average annual Medicaid cost for aged and disabled QMB's/SLIMBY's and $750 annual cap for other aged/disabled up to 150% of poverty regardless of condition with a $6 co-pay | $137.6 million | 136,310 |
| • Provide average annual Medicaid cost for aged and disabled QMB's/SLIMBY's and $500 annual cap for other aged/disabled up to 150% of poverty regardless of condition with a $6 co-pay | $108.8 million | 136,310 |

| | | |
|---|---|---|
| **Aged & Disabled Up to 150% of Poverty**<br>**Estimates below assume 30% of income eligibles also meet QMB asset test** | | |
| • Provide average annual Medicaid cost for all eligibles regardless of condition with $6 co-pay | $198.2 million | 81,786 |
| • Provide average annual Medicaid cost for all eligibles regardless of condition with $15 co-pay | $192.3 million | 81,786 |

| | | |
|---|---|---|
| • Provide maximum $300 annual benefit regardless of condition (assumes $6 or $15 co-pay) | $24.5 million | 81,786 |
| • Provide maximum $400 annual benefit regardless of condition (assumes either $6 or $15 co-pay) | $32.7 million | 81,786 |
| • Provide maximum $500 annual benefit regardless of condition (assumes either $6 or $15 co-pay) | $40.9 million | 81,786 |
| • Provide maximum $750 annual benefit regardless of condition (assumes either $6 or $15 co-pay) | $61.3 million | 81,786 |
| • Provide average annual Medicaid rate only for diabetes and CVD for aged and disabled with $6 co-pay | $74.1 million | 63,253 (duplicated) |
| • Provide average annual Medicaid rate only for diabetes and CVD for aged and disabled with $15 co-pay | $65.3 million | 63,253 (duplicated) |
| • Provide $300 maximum annual benefit only for those with diabetes and CVD and $6 or $15 co-pay | $18.9 million | 63,253 (duplicated) |
| • Provide $400 maximum annual benefit only for those with diabetes and CVD and $6 or $15 co-pay | $25.3 million | 63,253 (duplicated) |
| • Provide $500 maximum annual benefit only for those with diabetes and CVD and $6 or $15 co-pay | $31.6 million | 63,253 (duplicated) |
| • Provide $750 maximum annual benefit only for those with diabetes and CVD (assumes 30% meet QMB asset test) and $6 or $15 co-pay | $47.4 million | 63,253 (duplicated) |
| • Provide average annual Medicaid cost for aged and disabled QMB's/SLIMBY's and $750 annual cap for other aged/disabled up to 150% of poverty regardless of condition with a $6 co-pay | $96.7 million | 81,786 |
| • Provide average annual Medicaid cost for aged and disabled QMB's/SLIMBY's and $500 annual cap for other aged/disabled up to 150% of poverty regardless of condition with a $6 co-pay | $81.6 million | 81,786 |

**Appendix 4**

# Comprehensive Listing of Cost Estimates and Coverage Scenarios Considered by Work Group for SFY 2001 (Includes a 13.05% Rebate)

**QMB/SLIMBYS -- Aged & Disabled Up to 120% of Poverty**

| | Cost | People |
|---|---|---|
| Flat Dollar Cap Approach | | |
| • Provide maximum $300 annual benefit per eligible regardless of condition (assumes either $6 or $15 co-pay) | $5.5 million | 21,253 |
| • Provide maximum $400 annual benefit per eligible regardless of condition (assumes $6 or $15 co-pay) | $7.4 million | 21,253 |
| • Provide maximum $500 annual benefit per eligible regardless of condition (assumes $6 or $15 co-pay) | $9.2 million | 21,253 |
| • Provide maximum $750 annual benefit regardless of condition (assumes $6 or $15 co-pay) | $13.9 million | 21,253 |
| • Provide maximum $300 annual benefit for all eligible with diabetes and CVD only (assumes either $6 or $15 co-pay) | $3.7 million | 14,106 (duplicated) |
| Capped Amounts Tied to Average Annual Medicaid Costs | | |
| • Provide same average annual per person cost as Medicaid regardless of diagnosis (average annual costs adjusted for inflation)with $6 co-pay per prescription | $44.6 million | 21,253 |
| • Provide same average annual per person cost as Medicaid (adjusted for inflation) regardless of diagnosis with $15 co-pay | $43.3 million | 21,253 |
| • Provide same average annual Medicaid level of assistance (adjusted for inflation) for diabetes and CVD only with $6 co-pay | $14.2 million | 14,106 (duplicated) |
| • Provide same average annual Medicaid level of assistance for diabetes and CVD only with $15 co-pay | $12.5 million | 14,106 (duplicated) |

**QMB's/SLIMBY's & QI's Up to 175% of Poverty**

| | | |
|---|---|---|
| • Provide maximum $300 annual benefit per eligible regardless of condition (assumes either a $6 or $15 co-pay per prescription) | $7.0 million | 27,000 |
| • Provide maximum $400 annual benefit per eligible regardless of condition (assumes either a $6 or $15 co-pay per prescription) | $9.4 million | 27,000 |
| • Provide maximum $500 annual benefit per eligible regardless of condition (assumes either a $6 or $15 co-pay per prescription) | $11.7 million | 27,000 |
| • Provide maximum $750 annual benefit per eligible regardless of condition (assumes either a $6 or $15 co-pay per prescription) | $17.6 million | 27,000 |
| • Provide same average annual per person cost as Medicaid regardless of condition with a $6 co-pay. | $56.6 million | 27,000 |
| • Provide same average annual per person cost as Medicaid regardless of condition with a $15 co-pay. | $54.9 million | 27,000 |

**Aged & Disabled Up to 150% of Poverty**
**Estimates below assume 50% of income eligibles also meet QMB asset test**

| | | |
|---|---|---|
| • Provide average annual Medicaid cost for all eligibles regardless of condition with $6 co-pay | $287.3 million | 136,310 |
| • Provide average annual Medicaid cost for all eligibles regardless of condition with $15 co-pay | $278.7 million | 136,310 |
| • Provide $300 maximum annual benefit for all eligibles regardless of condition with $6 or $15 co-pay | $35.5 million | 136,310 |
| • Provide $400 maximum annual benefit for all eligibles regardless of condition with $6 or $15 co-pay | $47.4 million | 136,310 |
| • Provide $500 maximum annual benefit for all eligibles regardless of condition with $6 or $15 co-pay | $59.2 million | 136,310 |
| • Provide $750 maximum annual benefit for all eligibles regardless of condition with $6 or $15 co-pay | $88.9 million | 136,310 |
| • Provide Medicaid average annual cost for diabetes and CVD only with $6 co-pay | $107.4 million | 105,422 (duplicated) |
| • Provide Medicaid average annual cost for diabetes and CVD only with $15 co-pay | $94.7 million | 105,422 (duplicated) |
| • Provide maximum $300 annual benefit for those with diabetes and CVD only with a $6 or $15 co-pay | $27.5 million | 105,422 (duplicated) |
| • Provide maximum $400 annual benefit for those with diabetes and CVD only with a $6 or $15 co-pay | $36.6 million | 105,422 (duplicated) |
| • Provide maximum $500 annual benefit for those with diabetes and CVD only with a $6 or $15 co-pay | $45.8 million | 105,422 (duplicated) |
| • Provide maximum $750 annual benefit for those with diabetes and CVD only with a $6 or $15 co-pay | $68.7 million | 105,422 (duplicated) |
| • Provide average annual Medicaid cost for aged and disabled QMB's/SLIMBY's and $750 annual cap for other aged/disabled up to 150% of poverty regardless of condition with a $6 co-pay | $119.6 million | 136,310 |
| • Provide average annual Medicaid cost for aged and disabled QMB's/SLIMBY's and $500 annual cap for other aged/disabled up to 150% of poverty regardless of condition with a $6 co-pay | $94.6 million | 136,310 |

**Aged & Disabled Up to 150% of Poverty**
**Estimates below assume 30% of income eligibles also meet QMB asset test**

| | | |
|---|---|---|
| • Provide average annual Medicaid cost for all eligibles regardless of condition with $6 co-pay | $172.3 million | 81,786 |
| • Provide average annual Medicaid for all eligibles regardless of condition with $15 co-pay | $167.2 million | 81,786 |
| • Provide maximum $300 annual benefit regardless of condition (assumes $6 or $15 co-pay) | $21.3 million | 81,786 |
| • Provide maximum $400 annual benefit regardless of condition (assumes either $6 or $15 co-pay) | $28.4 million | 81,786 |
| • Provide maximum $500 annual benefit regardless of condition (assumes either $6 or $15 co-pay) | $35.5 million | 81,786 |
| • Provide maximum $750 annual benefit regardless of condition (assumes either $6 or $15 co-pay) | $53.3 million | 81,786 |
| • Provide average annual Medicaid rate only for diabetes and CVD for aged and disabled with $6 co-pay | $64.5 million | 63,253 (duplicated) |
| • Provide average annual Medicaid rate only for diabetes and CVD for aged and disabled with $15 co-pay | $56.8 million | 63,253 (duplicated) |
| • Provide $300 maximum annual benefit only for those with diabetes and CVD and $6 or $15 co-pay | $16.5 million | 63,253 (duplicated) |
| • Provide $400 maximum annual benefit only for those with diabetes and CVD and $6 or $15 co-pay | $22.0 million | 63,253 (duplicated) |
| • Provide $500 maximum annual benefit only for those with diabetes and CVD and $6 or $15 co-pay | $27.5 million | 63,253 (duplicated) |
| • Provide $750 maximum annual benefit only for those with diabetes and CVD (assumes 30% meet QMB asset test) and $6 or $15 co-pay | $41.2 million | 63,253 (duplicated) |
| • Provide average annual Medicaid cost for aged and disabled QMB's/SLIMBY's and $750 annual cap for other aged/disabled up to 150% of poverty regardless of condition with a $6 co-pay | $84.0 million | 81,786 |
| • Provide average annual Medicaid cost for aged and disabled QMB's/SLIMBY's and $500 annual cap for other aged/disabled up to 150% of poverty regardless of condition with a $6 co-pay | $70.9 million | 81,786 |

** Note: All cost estimates in Appendix 4 are based on the same assumptions listed in Appendix 5 except that these estimates assume an average manufacturer rebate of 13.05% which is the average of the minimum Medicaid rebate required for generic drugs (11%) and brand name drugs (15.1%).*

**Appendix 5**

# Assumptions Upon Which Cost Estimates Were Developed

- Number of eligible QMB's/SLIMBY's for 2001 (and projections through 2005 where appropriate) based on projections by the Division of Medical Assistance and adjusted to assume that 3.9% would have private insurance coverage for drugs (e.g. employer, through spouse's employer, etc.). Estimate of 3.9% based on analysis and assumptions relating to current population survey data projections of 65+ population with health insurance coverage by income strata (1998 & 1999 data). 3.9% of disabled also assumed to have private insurance coverage. Ratio of aged versus disabled QMB'/SLIMBY's based on same ratio of aged and disabled QMB's/SLIMBY's as of actual enrollment 2/10/2000.
- Cost estimates for QMB's/SLIMBY's up to 175% of poverty based on actual (and projected) monthly enrollment of QI's provided by Division of Medical Assistance for the period (June 1999 through June 2000) and trended forward. Estimates then adjusted for those assumed to have some private insurance coverage for drugs.
- All cost estimates that peg assistance to the average annual per person cost paid by Medicaid are based on projections for 2001 (and out years where appropriate) for the elderly and disabled Medicaid population as developed by the Division of Medical Assistance (4/5/2000). Base rates are then adjusted to reflect co-payment requirements for various coverage options.
- Population of potential elderly eligibles up to 150% of poverty based on income to poverty ratio data for persons 65+ and applied to population estimates for those 65+. Since it is expected that the 2000 census will show some reduction in NC's poverty rate among the elderly, current assumptions regarding income to poverty percentages are expected to be a worse case scenario. (*Same methodology applied to years 2002-2005 for work group priorities 2 and 3 and adjusted for QMB/SLIMBY population without full Medicaid or other drug coverage).*
- Potential income eligible 65+ population (as calculated above) adjusted to take into account the number expected to have full Medicaid coverage as well as number expected to have drug coverage through private insurance (assumes 3.9% have private coverage -- same source data as referenced above).
- Disabled eligibles meet definition of disability as established by the Social Security Administration (SSA). SSA provided total numbers of disabled adults 18-64 in North Carolina in 1997. Calculation made to determine projected number of disabled in 2001 based on 1997 data trended forward. Projected number of disabled 18-64 without drug coverage adjusted to take into account projected number of disabled projected to receive full Medicaid coverage also assumes 3.9% will have some private insurance coverage for drugs.
- Assumes same income to poverty ratio for disabled as used for persons 65+ since no income to poverty data or asset data available for this particular segment of the population and since disabled adults likely to have a higher level of poverty than the general 18-64 population. Also assumes 3.9% of disabled will have private insurance coverage for prescription drugs (same percentage as used for elderly) as worse case scenario.
- Assumes all income eligibles would also have to meet asset test (same as used for QMB population). No asset data available so two different assumptions have been made regarding percentage of income eligibles likely to also meet asset test. While estimate of 30% (30% of income eligibles also meet asset test) likely to be more realistic, a second estimate assuming 50% would also meet asset test is included as a worse case scenario.
- As worse case scenario, cost estimates assume all persons projected to be served would use the maximum benefit available.
- Medicaid data for specific disease categories based on reported expenditures in appropriate therapeutic class codes (diabetes and cardiovascular related drugs) for the elderly/disabled population in SFY 99 and adjusted for inflation based on same percentage increase as for average annual per person cost for prescription drugs for the elderly and disabled between SFY 1999 and 2001 based on projections provided by the Division of Medical Assistance.
- No manufacturer rebates are assumed in the estimates in order to present a fiscal 'worst case scenario'..
- Prevalence rate data for diabetes is North Carolina specific. Prevalence rates by age groups applied to 65+ population and 18-64 population projected for 2001. Prevalence rate data obtained from Ronnie Bell, contract statistician, working with the Division of Public Health. Overall calculated prevalence rate for 65+ is 15.20% and overall prevalence rate for 18-64 population is 5.48%.
- Overall prevalence rate for cardiovascular disease for 65+ population is 70.12% and 20.66% for 18-64 population. Prevalence rate data applied to 65+ population and disabled population 18-64. Sources for prevalence rate data --1999 Heart and Stroke Statistical Update, American Heart Association.
- Assumes 40 cents of the $6 co-pay (or $15 co-pay for scenarios with a $15 co-pay) will be used to cover claims processing fee by claims processor.
- All cost estimates that include estimates through 2005 reflect annual changes in the 65+ and 18-64 population as projected by the Office of State Planning -- *County Projected Age Group Totals* for years indicated (Office of State Planning estimates as of 3/31/2000).
- All estimates for SFY 2001 assume a full year.

# Footnotes

[1] AARP Bulletin, *Just the Facts: Prescription Drugs*, September 1999 Issue, p. 32.

[2] Information provided by Sally Burner, Actuary, Health Care Financing Administration, Baltimore, Maryland. (April 25, 2000).

[3] Steinberg, E., *Beyond Data: A Claims-Based Analysis of Drug Use and Spending By the Elderly.* Health Affairs. March/April 2000 Issue. http://www.projhope.org/HA/marapr00/currentissue.htm.

[4] Information provided by Richard Cobb, Budget Officer, North Carolina Division of Medical Assistance (December 13, 1999).

[5] Information provided by Carla Obiol, Director of Seniors' Health Insurance Information Program, North Carolina Department of Insurance (April 5, 2000).

[6] BNA, Health Care Policy Report. *NAIC to Study Requiring All Medigap Plans to Include Coverage for Prescription Drugs.* March 27, 2000 Issue.

[7] Report to the President. *Prescription Drug Coverage, Spending, Utilization, and Prices.* Department of Health and Human Services. April 2000.

[8] Aging Network News. *Clinton Promises $160B for Drugs, Goes Head-to-Head with GOP Legislation.* February 14, 2000 Issue. p. 1.

[9] *Ibid #6.*

[10] Information for this section obtained from National Conference of State Legislatures' report entitled *State Senior Pharmaceutical Assistance Programs.* November 1999; AARP Public Policy Institute Report, *State Pharmacy Assistance Programs.* April 1999; and Older Americans Report, *Prescription Drugs: Outreach, Low Enrollment Are Major Concerns for State Rx Drug Program.* March 31. 2000. p. 109.

[11] QMB/SLIMBY enrollment data provided by North Carolina Division of Medical Assistance. Enrollment as of February 10, 2000.

[12] Calculated percentage based on age specific categories of prevalence rate published by the American Heart Association - 1999 Hearth and Stroke Statistical Update.

[13] Age specific North Carolina prevalence rate data for diabetes obtained from Ronnie Bell, Contract Statistician working with the North Carolina Division of Public Health.

[14] *Surveillance for Selected Public Health Indicators Affecting Older Adults – United States.* Department of Health and Human Services. Centers for Disease Control and Prevention. December 17, 1999. Volume 48/No.SS.8.

[15] *Ibid #14*

[16] Information provided by Genevieve Dutton, Statistician, North Carolina Central Cancer Registry, State Center for Health Statistics (April 4, 2000).